

STATE OF ILLINOIS

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Facility Name & ID Number Gaylord Tull House# 0032672 Report Period Beginning: 10/01/04 Ending: 09/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,463</u>			<u>5,463</u>	13
14	TOTALS	<u>5,463</u>			<u>5,463</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.54%

D. How many bed-hold days during this year were paid by the Department?

87 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 09/29/87

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 09/29/87 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12/31/05 Fiscal Year: 09/30/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number

Gaylord Tull House

0032672

Report Period Beginning:

10/01/04

Ending:

09/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	33,715	39	1,148	34,902		34,902		34,902			1
2	Food Purchase		29,132		29,132		29,132	49	29,181			2
3	Housekeeping	23,883	5,611		29,494		29,494	40	29,534			3
4	Laundry	11,636	999		12,635		12,635		12,635			4
5	Heat and Other Utilities			14,306	14,306		14,306	1,650	15,956			5
6	Maintenance			63,520	63,520		63,520	(25,338)	38,182			6
7	Other (specify):*											7
8	TOTAL General Services	69,234	35,781	78,974	183,989		183,989	(23,599)	160,390			8
	B. Health Care and Programs											
9	Medical Director		20,225	3,000	23,225		23,225		23,225			9
10	Nursing and Medical Records	124,600	313	42,281	167,194		167,194	(13,025)	154,169			10
10a	Therapy											10a
11	Activities	17,080	2,716		19,796		19,796		19,796			11
12	Social Services			2,450	2,450		2,450	(2,450)				12
13	CNA Training	20,085			20,085		20,085		20,085			13
14	Program Transportation			3,214	3,214		3,214	163	3,377			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	161,765	23,254	50,945	235,964		235,964	(15,312)	220,652			16
	C. General Administration											
17	Administrative	53,507		77,940	131,447		131,447	(51,361)	80,086			17
18	Directors Fees											18
19	Professional Services			4,615	4,615		4,615	2,705	7,320			19
20	Dues, Fees, Subscriptions & Promotions			3,309	3,309		3,309	426	3,735			20
21	Clerical & General Office Expenses	11,636	3,858	11,047	26,541		26,541	13,928	40,469			21
22	Employee Benefits & Payroll Taxes			56,683	56,683		56,683	13,925	70,608			22
23	Inservice Training & Education			367	367		367	236	603			23
24	Travel and Seminar							2,597	2,597			24
25	Other Admin. Staff Transportation			1,377	1,377		1,377	2,132	3,509			25
26	Insurance-Prop.Liab.Malpractice			6,893	6,893		6,893	2,736	9,629			26
27	Other (specify):*											27
28	TOTAL General Administration	65,143	3,858	162,231	231,232		231,232	(12,676)	218,556			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	296,142	62,893	292,150	651,185		651,185	(51,587)	599,598			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Gaylord Tull House

#0032672

Report Period Beginning:

10/01/04

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			12,543	12,543		12,543	13,929	26,472			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			747	747		747	9,913	10,660			32
33	Real Estate Taxes			7,288	7,288		7,288	2,085	9,373			33
34	Rent-Facility & Grounds			46,525	46,525		46,525	389	46,914			34
35	Rent-Equipment & Vehicles							452	452			35
36	Other (specify):*											36
37	TOTAL Ownership			67,103	67,103		67,103	26,768	93,871			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,460	44,460		44,460		44,460			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			44,460	44,460		44,460		44,460			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	296,142	62,893	403,713	762,748		762,748	(24,819)	737,929			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Gaylord Tull House**# **0032672**Report Period Beginning: **10/01/04**Ending: **09/30/05****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule Sch. VIII & XIX-H	(24,819)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (24,819)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (24,819)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Gaylord Tull House

ID# 0032672

Report Period Beginning: 10/01/04

Ending: 09/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

09/30/05

[illegible]

Summary B

09/30/05

09/30/05

[illegible]

Facility Name & ID Number Gaylord Tull House# 0032672

Report Period Beginning:

10/01/04

Ending:

09/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule VII C		See Attached Schedule		Health Services Cons.	Champaign, IL	Consulting
				Cobblestone Rehab.	Champaign, IL	Therapy
				Specialized Developme	Champaign, IL	Long Term Care
				The Residential Develo	Champaign, IL	Long Term Care
				MBD, LLC	Champaign, IL	Rental Real Estate
				P&L Rentals, LLC	Champaign, IL	Rental Real Estate

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Schedule VIII	\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gaylord Tull House # 0032672 Report Period Beginning: 10/01/04 Ending: 09/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Alan Ryle	President	Administrative	60.00	All related party wages are allocations			Administrative	\$ 3,222	17-7	1
2	Lynn Ryle	Vice-President	Administrative	0.00	from HSC. See attached allocation			Administrative	1,277	17-7	2
3	Patti Hood			40.00	spreadsheet and explanation. These					18-7	3
4					individuals receive no compensation from						4
5					entities other than HSC.						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,499		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gaylord Tull House# 0032672

Report Period Beginning:

10/01/04Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Health Services Consultants, Inc.Street Address P.O. Box 3037City / State / Zip Code Champaign, IL 61826Phone Number (217) 398-3754Fax Number (217) 3938-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10 Nursing	Reverse expenses for actual amounts paid and accrued to			\$	\$		(30,735)	1
2	12 Social	HSC for services provided in order to allocate HSC's						(2,450)	2
3	17 Administrative	actual expenses.						(77,940)	3
4	21 Clerical							(6,563)	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13	1 Dietary	Beds	400	207			16		13
14	2 Food Purchases	Beds	400	207			16		14
15	3 Housekeeping	Beds	400	207	992		16	40	15
16	5 Heat & Utilities	Beds	400	207	41,239		16	1,650	16
17	6 Maintenance	Beds	400	207	141,680	69,567	16	8,754	17
18	9 Medical Director	Beds	400	207			16		18
19	10 Nursing	Beds	400	207	262,309	208,140	16	17,710	19
20	11 Activities	Beds	400	207			16		20
21	12 Social	Beds	400	207			16		21
22	13 Nurse Training	Beds	400	207			16		22
23	14 Program Transportation	Beds	400	207			16		23
24	17 Administrative	Beds	400	207	479,307	479,307	16	26,579	24
25	TOTALS				\$ 925,527	\$ 757,014		\$ (62,955)	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gaylord Tull House# 0032672 Report Period Beginning: 10/01/04Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Health Services Consultants, Inc.Street Address P.O. Box 3037City / State / Zip Code Champaign, IL 61826Phone Number (217) 398-0754Fax Number (217) 398-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18 Director Fees	Beds	400	207	\$	\$	16	\$	1
2	19 Professional Fees	Beds	400	207	67,292		16	2,692	2
3	20 Dues & Subscriptions	Beds	400	207	9,348		16	374	3
4	21 Clerical	Beds	400	207	450,880	335,463	16	19,185	4
5	22 P/R Taxes & Benefits	Beds	400	207	527,878		16	13,601	5
6	23 Inservice	Beds	400	207	5,908		16	236	6
7	24 Travel & Seminar	Beds	400	207	58,377		16	2,335	7
8	25 Administrative Transportation	Beds	400	207	53,288		16	2,132	8
9	26 Insurance	Beds	400	207	62,315		16	2,493	9
10	30 Depreciation	Beds	400	207	333,750		16	13,350	10
11	32 Interest	Beds	400	207	202,504		16	8,100	11
12	33 Real Estate Tax	Beds	400	207	52,134		16	2,085	12
13	34 Building Lease	Beds	400	207			16		13
14	35 Equipment Lease	Beds	400	207	11,294		16	452	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,760,495	\$ 1,092,477		\$ 4,080	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gaylord Tull House# 0032672

Report Period Beginning:

10/01/04Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Developmental Foundations, Inc.Street Address P.O. Box 3037City / State / Zip Code Champaign, IL 61826Phone Number (217) 398-0754Fax Number (217) 398-0944

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>1</u> Dietary	<u>Beds</u>	<u>79</u>	<u>5</u>	\$	\$	<u>16</u>	\$	1
2	<u>2</u> Food Purchases	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>241</u>		<u>16</u>	<u>49</u>	2
3	<u>5</u> Utilities	<u>Beds</u>	<u>79</u>	<u>5</u>			<u>16</u>		3
4	<u>6</u> Maintenance	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>2,332</u>		<u>16</u>	<u>472</u>	4
5	<u>9</u> Medical Director	<u>Beds</u>	<u>79</u>	<u>5</u>			<u>16</u>		5
6	<u>14</u> Program Transportation	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>803</u>		<u>16</u>	<u>163</u>	6
7	<u>19</u> Professional Services	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>63</u>		<u>16</u>	<u>13</u>	7
8	<u>20</u> Fees, Subs & Promos	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>257</u>		<u>16</u>	<u>52</u>	8
9	<u>21</u> Clerical & Gen Office	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>6,449</u>		<u>16</u>	<u>1,306</u>	9
10	<u>22</u> Employee Ben. & P/R Tax	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>1,598</u>		<u>16</u>	<u>324</u>	10
11	<u>23</u> Inservice Training & Educ	<u>Beds</u>	<u>79</u>	<u>5</u>			<u>16</u>		11
12	<u>24</u> Travel & Seminars	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>1,294</u>		<u>16</u>	<u>262</u>	12
13	<u>26</u> Insurance	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>1,198</u>		<u>16</u>	<u>243</u>	13
14	<u>30</u> Depreciation	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>2,857</u>		<u>16</u>	<u>579</u>	14
15	<u>32</u> Interest	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>8,950</u>		<u>16</u>	<u>1,813</u>	15
16	<u>34</u> Building Lease	<u>Beds</u>	<u>79</u>	<u>5</u>	<u>1,920</u>		<u>16</u>	<u>389</u>	16
17	<u>35</u> Equipment Lease	<u>Beds</u>	<u>79</u>	<u>5</u>			<u>16</u>		17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 27,962	\$		\$ 5,665	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2	GMAC		x	Vehicle	\$642.00	8/14/03	38,502	22,460	8/14/08	zero			2
3													3
4													4
5													5
	Working Capital												
6	Bussey Bank		X	Line of Credit	N/A	N/A	N/A	N/A	N/A	N/A		747	6
7	Schedule VIII Allocations		X									9,913	7
8													8
9	TOTAL Facility Related				\$642.00		\$ 38,502	\$ 22,460				\$ 10,660	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$	14
15	TOTALS (line 9+line14)						\$ 38,502	\$ 22,460				\$ 10,660	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Gaylord Tull House**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

[illegible]

NOTES:

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gaylord Tull House COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0032672

CONTACT PERSON REGARDING THIS REPORT Sherry Newton

TELEPHONE (217) 398-0754 FAX #: (217) 398-0944

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>02-1-00516-00</u>	<u>Facility</u>	\$ <u>7,402.00</u>	\$ <u>7,402.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>7,402.00</u></u>	\$ <u><u>7,402.00</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

A. Square Feet:

4,600

B. General Construction Type:

Exterior

Aluminum Siding

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☐
 (a) Own the Facility

☐
 (b) Rent from a Related Organization.

☒
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒
 (a) Own the Equipment

☐
 (b) Rent equipment from a Related Organization.

☐
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐
 YES

☒
 NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Leasehold Improvements			1994	2,425	62	39	62		717	9	
10	Leasehold Improvements			1995	4,405	163	27	163		1,683	10	
11	Carpet, Furniture			1997	7,712	286	27	286		2,335	11	
12	Wall overing			2000	2,332	58	40	58		295	12	
13	Replace Exterior Doors (2)			2001	1,358	50	27	50		214	13	
14	Carpet & Tile			2002	5,686	211	27	211		645	14	
15	Carpet & Tile			2003	5,357	214	25	214		616	15	
16	Door			2005	745	50	5	50		50	16	
17	Tile Floor			2005	781	10	5	10		10	17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 30,801	\$ 1,104		\$ 1,104	\$	\$ 6,565	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 20,590	\$ 2,940	\$ 2,940		5/7	\$ 13,652	71
72	Current Year Purchases	2,665	152	152		7	152	72
73	Fully Depreciated Assets	6,494				7	6,494	73
74								74
75	TOTALS	\$ 29,749	\$ 3,092	\$ 3,092	\$		\$ 20,298	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1999 GMC Van	1999	\$ 25,283	\$ 49	\$ 49		5	\$ 25,283	76
77	Patient Transportation	2003 GMC Savana	2003	35,152	7,030	7,030		5	15,232	77
78	Patient Transportation	2000 GMC Savana	2000		1,268	1,268		5		78
79	(Line 78 Disposed during 2005)									79
80	TOTALS			\$ 60,435	\$ 8,347	\$ 8,347	\$		\$ 40,515	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 120,985	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 12,543	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 12,543	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 67,378	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Milestone Midwest, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1987	15	09/29/87	\$ 46,525	15	15	3
4	Additions	1991	1					4
5								5
6								6
7	TOTAL		16		\$ 46,525			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. N/A - month to \$ _____

13. month lease \$ _____

14. _____ \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER CNA <u>40</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER CNA <u>80</u>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)		6,695		6,695
4	Clinical Wages (b)		13,390		13,390
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	20,085	\$	20,085
10	SUM OF line 9, col. 1 and 2 (e)	\$	20,085		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	21

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
			# of prescrpts								
9	Pharmacy										9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	122,884		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 122,884	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	30,801		15
16	Equipment, at Historical Cost	90,184		16
17	Accumulated Depreciation (book methods)	(67,378)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 53,607	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 176,491	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,415		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,039		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 16,454	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	22,460		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 22,460	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 38,914	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 137,577	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 176,491	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 142,017	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 142,017	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(21,098)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (21,098)	17
	B. Transfers (Itemize):		
18	Transfers (to) from Developmental Foundations, Inc.	16,658	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 16,658	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 137,577	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Gaylord Tull House

0032672

Report Period Beginning: 10/01/04

Ending:

09/30/05

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 741,650	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 741,650	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 741,650	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	183,989	31
32	Health Care	235,964	32
33	General Administration	231,232	33
B. Capital Expense			
34	Ownership	67,103	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	44,460	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 762,748	40
41	Income before Income Taxes (line 30 minus line 40)**	(21,098)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (21,098)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Tax return is on a 12/31 fiscal year.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Gaylord Tull House# 0032672Report Period Beginning: 10/01/04Ending: 09/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies					5
6	CNA Trainees	2,520	2,520	20,085	7.97	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,331	1,472	11,262	7.65	9
10	Activity Assistants	730	730	5,818	7.97	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,336	2,411	19,170	7.95	14
15	Cook Helpers/Assistants	1,825	1,825	14,545	7.97	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	2,730	2,993	23,883	7.98	18
19	Laundry	1,460	1,460	11,636	7.97	19
20	Administrator	3,856	4,224	53,507	12.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,460	1,460	11,636	7.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	2,611	2,926	40,271	13.76	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	9,145	10,584	84,329	7.97	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	30,004	32,605	\$ 296,142 *	\$ 9.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 1,148	1-3	35
36	Medical Director		3,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant		29,576	10-3	38
39	Pharmacist Consultant		192	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant		5,561	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		3,148	10-3	43
44	Activity Consultant				44
45	Social Service Consultant		2,450	12-3	45
46	Other(specify)				46
47	Psychologist		2,001	10-3	47
48	Dentist		110	10-3	48
49	TOTAL (lines 35 - 48)		\$ 47,186		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gaylord Tull House# 0032672Report Period Beginning: 10/01/04Ending: 09/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description		Description		Description			
Jason Bronwell	Admin	None	\$ 7,366	Workers' Compensation Insurance	\$ 6,466	IDPH License Fee	\$ 1,201				
Torrey Langston	25% Admin	None	4,731	Unemployment Compensation Insurance	5,707	Advertising: Employee Recruitment	1,201				
Debra Ohnesorge	Admin	None	25,940	FICA Taxes	22,655	Health Care Worker Background Check	240				
Charles Rabb	25% Admin	None	8,693	Employee Health Insurance	11,873	(Indicate # of checks performed <u>13</u>)					
Josh Rieman	Admin	None	6,777	Employee Meals	5,462	Dues & Subscriptions	1,868				
				Illinois Municipal Retirement Fund (IMRF)*							
				Other	4,520						
				Schedule VIII Allocation	13,925	Schedule VIII Allocation	426				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 53,507							
B. Administrative - Other											
Description				Amount							
Management Support & Consulting				\$ 77,940							
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 77,940							
(Attach a copy of any management service agreement)											
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
Martin, Hood, Friese & Assoc.	Accounting		\$ 2,340	None			Out-of-State Travel	\$			
Various	Various		1,319								
Thomas, Mamer, & Haughey	Legal		956				In-State Travel				
							Schedule VIII Allocation	2,597			
							Seminar Expense				
							Entertainment Expense	()			
							(agree to Sch. V,				
TOTAL (agree to Schedule V, line 19, column 3)							line 24, col. 8)	\$ 2,597			
(If total legal fees exceed \$2500 attach copy of invoices.)				\$ 4,615	TOTAL						

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Roofing Repairs	7/05	\$ 16,845	5	\$ 562	\$ 3,369	\$ 3,369	\$ 3,369	\$ 3,369	\$ 2,807	\$	\$	\$
2	Bathroom Repairs	9/05	18,591	5	310	3,718	3,718	3,718	3,718	3,408			
3													
4													
5													
6													
7													
8													
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16													
17													
18													
19													
20	TOTALS		\$ 35,436		\$ 872	\$ 7,087	\$ 7,087	\$ 7,087	\$ 7,087	\$ 6,215	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Gaylord Tull House

STATE OF ILLINOIS

0032672

Report Period Beginning:

10/01/04

Ending:

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09/30/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IARF - \$956
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5/7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 44,460
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 5,462 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? Attached
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? None
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.